| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 335390 | A. Building<br>B. Wing | 12/22/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Surge Rehabilitation and Nursing LLC | 49 Oakcrest Ave<br>Middle Island, NY 11953 |

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| F 0610<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Respond appropriately to all alleged violations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure that all allegations of abuse, neglect, and mistreatment were thoroughly investigated; failed to put measures in place to prevent further potential abuse, neglect, exploitation or mistreatment; and failed to report results of the investigation to the New York State Department of Health within five (5) working days of the incident. This was identified for two (2) (Resident #96 and Resident #98) of three (3) residents reviewed for Abuse. Specifically, on 11/30/2025, Licensed Practical Nurse #1 received an allegation of physical abuse concerning Resident #96 from the resident's family member. The facility Administrator was not made aware of the incident until 12/01/2025. Resident #96 was discharged from the facility on 12/10/2025. [NAME] Resident #96 was discharged from the facility on 12/10/2025, their former roommate (Resident #98) reported to Registered Nurse #1 that they witnessed Resident #96 being slapped by an unidentified staff member. Registered Nurse #1 reported this allegation to License Practical Nurse #1 who was serving as the charge nurse. Licensed Practical Nurse #1 did not report this second allegation to the facility Administration. There was no documented evidence that an investigation was initiated for either allegation, as a result the facility did not take steps to protect residents from potential abuse. This resulted in no actual harm to Resident #96 with potential for serious injury, harm, impairment, or death for 131 residents residing in the facility that is Immediate Jeopardy.The finding is:The facility's policy titled Abuse Identification and Investigation; Prevention and Reporting last reviewed 09/02/2025, documented that all incidents should be investigated to rule out potential abuse. Allegations of abuse will be investigated; other injuries will be investigated to rule out abuse potential. The facility will conduct a thorough investigative procedure by interviewing the resident, staff, visitors where appropriate; assessing the resident; reviewing the medical record and including any pertinent diagnostic and any other relevant information. The result of the investigation will be completed within five (5) days and provided to the New York State Department of Health. The policy documented that any type of abuse can be perpetrated from staff to resident, where the resident is the victim, and a staff member is an aggressor. The physical abuse includes but is not limited to hitting, slapping, and punching. Even in cases where a staff member has a knee-jerk or responsive reaction to a resident, Staff to Resident abuse should be investigated. The facility will ensure the protection of the resident by responding immediately, assessing the alleged victim, increasing supervision as needed, changing room or staffing, and ensuring protection from retaliation.Resident #96 was admitted with diagnoses that included Parkinson's disease (a progressive brain disease), cognitive communication deficit, and bipolar disorder (causes extreme mood swings from high manic to depressive low). The admission Minimum Data Set (a resident assessment tool) dated 09/30/2025 documented a Brief Interview for Mental Status score of eight (8), which indicated the resident had moderately impaired cognition. Resident #96 had no behavioral or mood symptoms at the time of assessment.The Comprehensive Care Plan for potential for abuse dated 09/23/2025 documented interventions to encourage the resident to verbalize any concerns, fears or issue they may have. Monitor for any signs or symptoms of distress; report any suspected abuse via facility chain of command as per the policy and procedures. The care plan was not revised to reflect any actual<br>(continued on next page) |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|

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| F 0610<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | allegation of abuse. The Trauma Informed Care/Trauma/Post Traumatic Stress Disorder (PTSD) Comprehensive Care Plan dated 09/24/2025 documented Resident #96 had post traumatic stress disorder as evidenced by past abuse. Interventions included to monitor for trauma and re-traumatized episode and report the episode to the interdisciplinary team; speak directly to the resident; maintain a calm and supportive environment. The care plan was not revised to reflect any allegation of abuse.Resident #98 was admitted with diagnoses that included dementia (condition causes loss of memory and brain function), chronic obstructive pulmonary disease (lung disease) and type 2 diabetes mellitus(condition where body cannot metabolize blood sugar properly due body's lack of insulin or inability to use insulin). The admission Minimum Data Set, dated [DATE] documented a Brief Interview for Mental Status score of seven (7), which indicated the resident had moderately impaired cognition. The resident had no behavioral or mood symptoms at the time of the assessment.The Abuse Comprehensive Care Plan dated 10/30/2025 documented Resident #98 had potential for abuse. Interventions included to encourage resident to verbalize any concerns, fears or issue they may have and to monitor for any signs or symptoms of distress. The care plan was not revised to reflect any actual allegations of abuse.During the initial screening interview on 12/15/2025 at 01:13 PM, Resident #98 stated that about two (2) weeks ago at approximately 5:30 AM, an aide had entered their room and hit their roommate (Resident #96) on the head. Resident #98 stated they saw the reflection of the aide hitting Resident #96 on their television screen which was turned off at the time. Resident #98 was unable to recall the exact date of the incident and was unable to identify the alleged perpetrator. Resident #98 stated they reported the incident to a staff member on the same day of the incident but did not know the name of the staff member. Resident #98 stated that Resident #96 has been discharged from the facility.A review of the facility's Grievance and Accident and Incident Reports from 11/15/2025 to 12/15/2025 lacked documented evidence that an investigation was completed related to the physical abuse allegation made by Resident #98.A review of Resident #96's medical record indicated the resident was discharged from the facility on 12/10/2025 and was unavailable for interview and observation.During an interview on 12/16/2025 at 2:39 PM, the Administrator and the Director of Nursing Services concurrently stated that they both were not aware of any allegations of abuse related to Resident #96 that was reported by Resident #98 to any staff member. The Administrator stated there were no Accident and Incident Reports or grievances filed related to allegation of physical abuse towards Resident #96.During an interview on 12/19/2025 at 8:06 AM, Licensed Practical Nurse #1, the unit manager, stated Resident #98 did not report any allegations of physical abuse related to Resident #96. Licensed Practical Nurse # 1 stated that they were not aware of any abuse allegation involving Resident #96.During an interview on 12/19/2025 at 8:12 AM, Registered Nurse # 1, the 7:00 AM-3:00 PM medication nurse, stated that Resident #98 reported (date not recalled) that their roommate, Resident #96, was hit by an aide; however, they could not recall which aide. Registered Nurse #1 stated they could not remember the date Resident #98 had reported the incident to them. Registered Nurse #1 stated after they were told about the physical abuse allegation, they immediately reported to the unit manager (Licensed Practical Nurse #1).During a re-interview on 12/19/2025 at 8:21 AM, Licensed Practical Nurse #1 stated Resident #96's family member informed them that Resident #96 told the family member that someone hit them on the head twice. Licensed Practical Nurse #1 stated they could not recall the date of the report or when the incident took place. Licensed Practical Nurse # 1 stated that they did not initiate an investigation and did not document the incident, they were only required to stop the abuse activities from continuing and report the incident to their supervisor. Licensed Practical Nurse #1 stated they do recall reporting the abuse allegation to the Director of Nursing Services after Resident #96's family member had reported the abuse allegation to them. Licensed Practical Nurse #1 stated they were not informed by Registered Nurse #1 regarding the physical abuse allegations toward Resident #96 as reported by Resident #98. During an interview on 12/19/2025 at 10:28 AM, Resident #96's family member stated during their visit on 11/30/2025, Resident #96 reported they were hit on the head twice and were (continued on next page) |

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| F 0610<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | treated unkindly by an aide. The family member stated that they had taken Resident #96 out on pass on 11/27/2025 for Thanksgiving and returned the resident to the facility the same night. The family member stated that the resident could not recall the day of the incident. The family member believed the incident would have occurred somewhere between 11/27/2025 to 11/30/2025. The family member stated that Resident #96 gave a description of the aide as a black female who spoke with an accent, short- medium build, and had dark hair. The family member stated that they reported the physical abuse allegation to Licensed Practical Nurse #1 right after the resident told them. The family member stated Licensed Practical Nurse # 1 informed them they would file a report. The family member stated that within two (2) days after they reported the incident, the Administrator informed them they had investigated the allegation and were unable to identify the perpetrator.A review of the facility's Grievance and Accident and Incident Reports from 11/15/2025 to 12/15/2025 is no documented evidence the facility completed an investigation related to the physical abuse allegation made by Resident #96's family member. During a re-interview on 12/19/2025 at 11:01AM, Registered Nurse #1 stated Resident #98 had reported the physical abuse allegation towards Resident #96, after Resident #96 was discharged from the facility [12/10/2025]. Registered Nurse #1 stated Resident #98 did not recall the date and time of the incident. Registered Nurse #1 stated they were unable to assess Resident #96 because the resident was no longer in the facility. Registered Nurse #1 stated they reported the abuse allegation to Licensed Practical Nurse #1. Registered Nurse #1 stated that they did not document the incident or initiate an investigation because they were not aware that they had to. During an interview on 12/19/2025 at 01:04 PM, the Administrator stated they were first made aware of the physical abuse allegation on 12/01/2025 by Licensed Practical Nurse #1 related to Resident #96. The Administrator stated they and the Director of Nursing Services immediately interviewed Resident #96. The resident provided a detailed physical description of the aide; however, they were unable to establish a definite timeline and the specific shift when the incident allegedly occurred. The Administrator stated they identified Certified Nursing Assistant # 2 as the alleged perpetrator based on the description provided by the resident and the amount of time Certified Nursing Assistant #2 had provided care to the resident. The Administrator stated Resident #96 was shown a picture of Certified Nursing Assistant #2 and Resident #96 denied that Certified Nursing Assistant # 2 was the perpetrator. Certified Nursing Assistant # 2 also denied hitting Resident #96. The Administrator stated that no staff member was removed from the unit or the resident's assignment pending any investigation. The Administrator stated they did not document their investigation findings and did not report the incident to the New York State Department of Health because the 12/01/2025 reported incident did not present to them as an abuse allegation. The Administrator stated that an Accident and Incident report should have been initiated and completed related to the allegation of physical abuse that was made by Resident #96's family member on 11/30/2025 to identify root cause of the incident. The Administrator stated they were not aware of an allegation of physical abuse by a staff member towards Resident #96 that was made by Resident #98 to Registered Nurse #1.During an interview on 12/19/2025 at 01:55 PM, the Director of Nursing Services stated on 12/01/2025 Licensed Practical Nurse #1 notified them of allegation of physical abuse related to Resident #96. The Director of Nursing Services stated they assessed Resident #96. There were no negative findings; however, they did not document the assessment and should have. The Director of Nursing Services stated Resident #96 provided a physical description and stated that the staff person was someone who had regularly cared for them. The Director of Nursing Services stated that resident told them that the incident had occurred after dinner and before night shift (11:00 PM); however, could not recall the date of the incident. The Director of Nursing Services stated that resident reported to them and the Administrator that when the aide was rolling them (Resident #96) over to clean during incontinence care, the aide hit them in the back of the head. Certified Nursing Assistant #2 was identified as the alleged perpetrator even though Certified Nursing Assistant #2 did not completely match the physical description. The Director of Nursing Services stated Resident #96 was also shown a picture of<br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Certified Nursing Assistant # 2 and Resident #96 denied that Certified Nursing Assistant # 2 was the perpetrator. Certified Nursing Assistant # 2 was interviewed and denied hitting Resident #96. The Director of Nursing Services stated they concluded no abuse had occurred based on the re-enactment they conducted on their own with the resident and believed that the incident was most likely due to poor care technique. The Director of Nursing Services stated they did not conduct any re-enactment with any staff member including Certified Nursing Assistant #2 who had cared for Resident #96 between 11/27/2025 through 11/30/2025. The Director of Nursing Services stated they did not document their investigative findings and did not remove any staff member from the unit or the resident's assignment pending their investigation. During a re-interview on 12/19/2025 at 03:11 PM, Resident #96's family member stated that Resident #96 denied any physical pain or injury after being hit in the head but was upset that the staff hit them (Resident #96) twice during care. The family member stated that Resident #96 remained in the same room on the same unit until their discharge on [DATE].During an interview on 12/22/2025 at 8:21AM, Certified Nursing Assistant #2 stated that they had cared for Resident #96 during the evening and night shift on various occasions with no concerns. Certified Nursing Assistant #2 stated they did not ever hit the resident. Certified Nursing Assistant #2 stated Resident #96 was able to support themselves and they did not need support to position their head. Certified Nursing Assistant #2 stated the Director of Nursing Services had questioned them regarding an allegation of physical abuse towards Resident #96 and were not reassigned to another unit.10 NYCRR 415.4(b)(3) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews initiated on 12/15/2025 and completed on 12/22/2025, the facility did not ensure that an established system of records of receipt and disposition of controlled drugs in sufficient detail to enable an accurate reconciliation is maintained. This was identified for one (1) (Resident #12) of one (1) resident reviewed for Dialysis. Specifically, Resident #12 had a Physician's order for Fentanyl (opioid pain medication) 50 microgram/hour transdermal patch (a medicated adhesive patch to deliver medication through the skin layers into the blood stream) to be applied to the chest wall every three (3) days. There was no documented evidence that on multiple days a second nurse was utilized as a witness to appropriately dispose the used Fentanyl Patch. The finding is: The facility's Handling of Fentanyl Patches policy and procedure last reviewed on 10/25/2025 documented to ensure Fentanyl transdermal patches are handled and disposed in such a manner as to minimize potential for diversion or abuse and comply with the state as well as the local regulations and ordinances. The disposal will take place in the presence of another licensed nurse and the signature and countersignature of disposal shall be noted on the resident's Medication Administration Record. Resident #12 was admitted with diagnoses that included end stage renal disease, bladder cancer, and lung cancer. The admission Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 15, which indicated the resident had intact cognition. The resident's pain intensity over the last 5 days was five (5) on a zero to ten scale. A Comprehensive Care Plan for Pain dated 11/11/2025 documented interventions that included to evaluate pain characteristic, causes and consequences, and to monitor for signs and symptoms of pain; to medicate per the Physician's orders, and to offer as needed medications when signs and symptoms of pain are present. A Physician's order dated 11/11/2025 documented Fentanyl Patch 50 microgram/hour transdermal patch. Apply one (1) patch by transdermal route to the chest wall every three (3) days. The Medication Administration Record for November 2025 documented Fentanyl 50 microgram/hour transdermal patch. Apply one (1) patch to the chest wall every three (3) days. The signature section of the Medication Administration Record revealed on 11/18/2025, 11/21/2025, 11/24/2025, 11/27/2025 and 11/30/2025 the same nurses signed for the Fentanyl patch removal and disposal, and as the witness. A Review of the Medication Administration Record dated 12/2025 documented Fentanyl 50 microgram/hour transdermal patch. Apply one (1) patch to the chest wall every three (3) days. The signature section of the Medication Administration Record revealed on 12/03/2025, 12/12/2025, 12/15/2025 and 12/18/2025 the same nurses signed for the Fentanyl patch removal and disposal, and as the witness. On 12/06/2025 there was no documented evidence of a witness signature for the disposal of the Fentanyl patch. During an interview on 12/17/2025 at 10:45 AM, Licensed Practical Nurse #10, who was the 7:00 AM - 3:00 PM medication nurse on duty on 11/24/2025 and 12/03/2025, stated that two nurses are required to be present for the disposal of the Fentanyl patch. Licensed Practical Nurse #10 stated that they remove the patch and ask a second nurse to witness them discarding the patch in the hazard bin (sharps container) attached to the medication cart. Licensed Practical Nurse #10 stated when they discard the patch, they sign the medication administration record as the nurse that removes and discards the patch. Licensed Practical Nurse #10 stated that their signature is seen as the witness to the disposal because the second nurse signed the medication administration record under their (Licensed Practical Nurse #10) account. Licensed Practical Nurse #10 stated that the second nurse was supposed to sign into the electronic medical record under their account and sign the medication administration record as the second nurse. Licensed Practical Nurse #10 stated that they could not recall the nurse who witnessed the disposal of the Fentanyl patch on 11/24/2025 and 12/03/2025. During an interview on 12/19/2025 at 8:21 AM, Licensed Practical Nurse #5, who was the 7:00 AM-3:00 PM medication nurse<br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | on duty on 12/12/2025, 1/15/2025 and 12/18/2025, stated two nurses are required for the disposal of the Fentanyl patch. One nurse removes and disposes the patch, and the second nurse is used as a witness. Both the nurses should sign the Medication Administration Record to confirm appropriate disposal of the Fentanyl patch. Licensed Practical Nurse #5 stated they thought a second nurse must witness them disposing the Fentanyl patch; however, they (Licensed Practical Nurse #5) had to sign the Medication Administration Record. Licensed Practical Nurse could not recall the nurse that witnessed the disposal of the Fentanyl Patch on 12/12/2025, 1/15/2025 and 12/18/2025. During an interview on 12/19/2025 at 8:41 AM, Licensed Practical Nurse #6 (Unit Manager) stated when the Fentanyl patch is removed, the patch should be folded with the sticky side together and a second nurse should witness to confirm the disposal of the Fentanyl patch. Licensed Practical Nurse #6 stated that the nurse who removes and discards the patch and who witnesses the disposal of the patch, must sign Medication Administration Record.During an interview on 12/22/25 at 10:33 AM, Licensed Practical Nurse #7 who was on duty on 11/18/2025, they stated two nurses must be present when disposing the used Fentanyl patch. The nurse who witnesses the disposal must sign the Medication Administration Record to confirm the appropriate disposal of the patch. Licensed Practical Nurse #7 stated that it was a mistake on their part that they signed, as the nurse who was disposing the Fentanyl patch and as a witness, on the Medication Administration Record. Licensed Practical Nurse #7 could not recall the nurse that witnessed the disposal on 11/18/2025.During an interview on 12/22/2025 at 11:07 AM, Licensed Practical Nurse #8 who was the medication nurse on duty on 11/21/2025 and 11/27/2025, stated they signed as the nurse who removed and discarded the Fentanyl patch and as the witness on Resident #12's Medication Administration Record. Licensed Practical Nurse #8 stated there was a second nurse who witnessed the disposal of the Fentanyl patch on 11/21/2025 and 11/27/2025; however, they could not recall the name of the nurse.During an interview on 12/22/2025 at 3:22 PM, the Director of Nursing Services stated two nurses must be present for the disposal of the Fentanyl patch as per the facility policy and both nurses must sign the Medication Administration Record to indicate the patch was disposed of properly. 10 NYCRR 415.18(b)(1)(2)(3) |

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| F 0583<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Keep residents' personal and medical records private and confidential.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility did not ensure that each resident had secure and confidential medical records. This was identified for one (1) (Resident #112) of eight (8) residents reviewed for the Medication Administration Task. Specifically, Licensed Practical Nurse #9 left Resident #112's electronic medical record open in the hallway with the resident's personal and medical information visible to other staff, residents, and visitors.The finding is: The facility's Administration of Medication policy dated 04/28/2025 documented the medication nurse will protect [residents' medical record] privacy by lowering the laptop screen or locking the screen. Resident #112 was admitted with diagnoses including cerebral infarction (sudden blockage of an artery supplying the brain), dysphagia (difficulty swallowing), and gastrostomy (tube feeding status). The Annual Minimum Data Set assessment dated [DATE] documented the resident could not complete the Brief Interview for Mental Status assessment because the resident was rarely or never understood. The resident was utilizing a feeding tube for nutrition. During an observation of the medication administration on 12/17/2025 at 4:55 AM, Licensed Practical Nurse #9 entered Resident #112's room and left Resident #112's medical record on the laptop screen unattended and visible to staff and residents in the hallway. A pharmacy delivery vendor was present in the hallway. During an interview on 12/17/2025 at 6:00 AM, Licensed Practical Nurse #9 stated they were supposed to turn the computer screen off so that the resident's medical record would not be visible to other residents, staff, and visitors. Licensed Practical Nurse #9 stated they forgot to turn the screen off. During an interview on 12/17/2025 at 07:03 AM, Registered Nurse Supervisor #4 stated the computer screen should have been closed to maintain the resident's privacy. During an interview on 12/19/2025 at 3:42 PM, the Director of Nursing Services stated the nurse should have turned the screen off or close the laptop to maintain the privacy of the resident's personal information. 10 NYCRR 415.3(e)(1) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure that all allegations of abuse, neglect, and mistreatment were reported immediately but not later than two (2) hours to the Administrator or the or the New York State Department of Health after the allegation was made, and failed to report results of the investigation to the New York State Department of Health within five (5) working days of the incident. This was identified for two (2) (Resident #96 and Resident #98) of three (3) residents reviewed for Abuse. Specifically, on 11/30/2025 Resident #96's family member reported an allegation of physical abuse towards Resident #96 to Licensed Practical Nurse #1. The facility Administrator was not made aware of the incident until 12/01/2025. A second allegation of physical abuse towards Resident #96 was reported by Resident #98 to Registered Nurse #1, who then reported the incident to Licensed Practical Nurse #1; however, neither Registered Nurse #1 nor Licensed Practical Nurse #1 reported the incident to the facility Administrator. Both incidents were not reported to the New York State Department of health within two (2) hours of the allegation of physical abuse. The finding is:The facility's policy titled Abuse Identification and Investigation; Prevention and Reporting last reviewed 09/02/2025, documented that any type of abuse can be perpetrated from staff to resident, where the resident is the victim, and a staff member is an aggressor. The physical abuse includes but is not limited to hitting, slapping, and punching. All allegations of abuse of a resident must be reported to the State Agency and one or more law enforcement entities within two hours, regardless of whether there is any injury. The facility will make its initial report to the New York State Department of Health within the reporting timeframes and requirements, and the results of the investigation will be submitted within five (5) working days of the incident. The facility will ensure the protection of the resident by responding immediately, assessing the alleged victim, increasing supervision as needed, changing room or staffing, and ensuring protection from retaliation. Resident #96 was admitted with diagnoses that included Parkinson's disease (a progressive brain disease), cognitive communication deficit, and bipolar disorder (causes extreme mood swings from high manic to depressive low). The admission Minimum Data Set (a resident assessment tool) dated 09/30/2025 documented a Brief Interview for Mental Status score of eight (8), which indicated the resident had moderately impaired cognition. The resident had no behavioral or mood symptoms at the time of assessment.The Comprehensive Care Plan for Abuse dated 09/23/2025 documented Resident #96 had potential for abuse. Interventions included to encourage the resident to verbalize any concerns, fears or issue they may have. Monitor for any signs or symptoms of distress; report any suspected abuse via facility chain of command as per the policy and procedures. The care plan was not revised to reflect any actual allegation of abuse. The Trauma Informed Care/Trauma/Post Traumatic Stress Disorder (PTSD) Comprehensive Care Plan, dated 09/24/2025, documented Resident #96 had post-traumatic stress disorder as evidence by past abuse. Interventions included to monitor for trauma and re-traumatized episodes and report the episode to the interdisciplinary team; speak directly to the resident; maintain a calm and supportive environment. The care plan was not revised to reflect any allegation of abuse.Resident #98 was admitted with diagnoses that included dementia (condition causes loss of memory and brain function), chronic obstructive pulmonary disease (lung disease) and type 2 diabetes mellitus (condition where body cannot metabolize blood sugar properly due body's lack of insulin or inability to use insulin). The admission Minimum Data Set, dated [DATE] documented a Brief Interview for Mental Status score of seven (7), which indicated the resident had moderately impaired cognition. The resident had no behavioral or mood symptoms at the time of the assessment.The Abuse Comprehensive Care Plan dated 10/30/2025 documented Resident #98 had potential for abuse. Interventions included to encourage resident to verbalize any concerns, fears or issue they may have and to monitor for any signs or symptoms of distress. The care plan was not<br>(continued on next page) |

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| | 335390 | A. Building<br>B. Wing | 12/22/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Surge Rehabilitation and Nursing LLC | 49 Oakcrest Ave<br>Middle Island, NY 11953 |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | revised to reflect any actual allegations of abuse.During the initial screening interview on 12/15/2025 at 01:13 PM, Resident #98 stated that about two (2) weeks ago at approximately 5:30 AM, an aide had entered their room and hit their roommate (Resident #96) on the head. Resident #98 stated they saw the reflection of the aide hitting Resident #96 on their television screen which was turned off at the time. Resident #98 was unable to recall the exact date of the incident and was unable to identify the alleged perpetrator. Resident #98 stated they reported the incident to a staff member on the same day of the incident but did not know the name of the staff member. Resident #98 stated that Resident #96 has been discharged from the facility.A review of the facility's Grievance and Accident and Incident Reports from 11/15/2025 to 12/15/2025 lacked documented evidence that an investigation was completed related to the physical abuse allegation made by Resident #98.A review of Resident #96's medical record indicated the resident was discharged from the facility on 12/10/2025 and was unavailable for interview and observation.During an interview on 12/16/2025 at 2:39 PM, the Administrator and the Director of Nursing Services concurrently stated that they both were not aware of any allegations of abuse related to Resident #96 that was reported by Resident #98 or any staff member. The Administrator stated there were no Accident and Incident Reports or grievances filed related to allegation of physical abuse towards Resident #96.During an interview on 12/19/2025 at 8:06 AM, Licensed Practical Nurse #1, the unit manager, stated Resident #98 did not report any allegations of physical abuse related to Resident #96. Licensed Practical Nurse # 1 stated that they were not aware of any abuse allegation towards Resident #96. During an interview on 12/19/2025 at 8:12 AM, Registered Nurse # 1, the 7:00 AM-3:00 PM medication nurse, stated that Resident #98 reported (date not recalled) that their roommate, Resident #96, was hit by an aide; however, they could not recall which aide. Registered Nurse #1 stated they could not remember the date Resident #98 had reported the incident to them. Registered Nurse #1 stated after they were told about the physical abuse allegation, they immediately reported to the unit manager (Licensed Practical Nurse #1).During a re-interview on 12/19/2025 at 8:21 AM, Licensed Practical Nurse # 1 stated Resident #96's family member informed them that Resident #96 told the family member someone hit Resident #96 on the head twice. Licensed Practical Nurse # 1 stated they could not recall the date of the report or when the incident took place. Licensed Practical Nurse #1 stated they do recall reporting the abuse allegation to the Director of Nursing Services after Resident #96's family member reported the abuse allegation to them. Licensed Practical Nurse # 1 stated they were not informed by Registered Nurse #1 regarding the physical abuse allegations towards Resident #96 as reported by Resident #98. During an interview on 12/19/2025 at 10:28 AM, Resident #96's family member stated during their visit on 11/30/2025, Resident #96 reported being hit on the head twice and being treated unkindly by an aide. The family member stated that the resident could not recall the day of the incident. The family member stated that they reported the physical abuse allegation to Licensed Practical Nurse # 1 right after the resident told them. The family member stated Licensed Practical Nurse # 1 informed them they would file a report. The family member stated that within two (2) days after they reported the incident, the Administrator informed them they had investigated the allegation and were unable to identify the perpetrator.During a re-interview on 12/19/2025 at 11:01AM, Registered Nurse #1 stated Resident #98 had reported the physical abuse allegation towards Resident #96, after Resident #96 was discharged from the facility [12/10/2025]. Registered Nurse #1 stated Resident #98 did not recall the date and time of the incident. Registered Nurse #1 stated they reported the abuse allegation to Licensed Practical Nurse #1.During an interview on 12/19/2025 at 01:04 PM, the Administrator stated they were first made aware of Resident #96's allegation of physical abuse on 12/01/2025 by Licensed Practical Nurse #1 based on the allegations made by Resident #96's family member on 11/30/2025. The Administrator stated they were not aware of Resident #98's allegation of physical abuse towards Resident #96. The Administrator stated any allegation of abuse must be reported to them and to the New York State Department of Health immediately. An investigation should have been initiated to rule out abuse neglect and mistreatment, and the results of the investigation should have<br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | been reported to the New York State Department of Health within five (5) working days. The Administrator stated they did not document their investigation findings and did not report the incident to the New York State Department of Health because the 12/01/2025 reported incident did not present to them as an abuse allegation.During an interview on 12/19/2025 at 01:55 PM, the Director of Nursing Services stated they were first made aware of Resident #96's allegation of physical abuse on 12/01/2025 by Licensed Practical Nurse #1. The Director of Nursing Services stated that they spoke with Resident #96 ruled out abuse within two (2) hours on 12/01/2025 after the allegation was reported to them by Licensed Practical Nurse #1 therefore, they did not report the abuse allegation to the New York State Department of Health. The Director of Nursing Services stated they did not document their communication with the resident or did not document the investigation findings. The Director of Nursing Services stated the facility must report to the New York State Department of Health any incident that clearly indicate abuse has occurred or when an abuse allegation cannot be ruled out within two (2) hours of after the allegation is made. 10 NYCRR 415.4(b)(2) |

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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility did not ensure that a copy of the notice of transfer or discharge was sent to a representative of the Office of the State Long Term Care Ombudsman. This was identified for one (1) (Resident #118) of two (2) residents reviewed for Hospitalization. Specifically, Resident #118 was transferred to the hospital for evaluation status post fall. There was no documented evidence that a Notice of Transfer or Discharge was sent to the Office of the State Long Term Care Ombudsman.The finding is: The facility's policy titled Transfer and discharge: Notice Requirement dated 04/28/2025 documented before the facility transfers or discharges a resident, the Social Worker or designee will notify the resident and the resident's representative of the transfer or discharge and the reasons for the move in writing in a language and manner they understand; and send a copy of the Notice to a representative of the Office of the State Long Term Care Ombudsman. Resident #118 was admitted with diagnoses that included left hip fracture and non-Alzheimer's dementia. A Significant Change Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score was three (3) which indicated the resident had severely impaired cognition. The resident has functional impairment to bilateral lower extremities and is dependent on staff for all areas of mobility and transfers. A nursing progress note dated 11/27/2025 documented Resident #118 sustained a fall and was found on the floor in the dining room near the wheelchair in a left lateral position. On assessment, the resident was grimacing with pain when touching the right shoulder and right hip. The physician was notified, and an x-ray was ordered for both arms and legs. A nursing progress note dated 11/27/2025 documented Resident #118 was sent to the hospital after their x-ray came back positive for a left hip fracture. At 9:00 PM, the resident was transferred via emergency medical technician per the physician's order. During an interview on 12/22/2025 at 1:52 PM, the Director of Social Services stated the ombudsman office was not notified when Resident #118 was transferred to the hospital. The Director of Social Services stated that during the ombudsman onsite visits, they offered to give the transfer and discharge notices to the Ombudsman, but the Ombudsman declined to take the notices. The Director of Social Services stated they received a notice recently from the ombudsman office notifying them that the transfer or discharge notices must be sent to the Office of the State Long Term Care Ombudsman. The Director of Social Services stated that the transfer or discharge notices were not being sent to the Ombudsman's office. The Director of Social Services stated that they could not recall the last time the transfer or discharge notices were sent to the Ombudsman office as required. The Director of Social Services stated that the transfer or discharge notices should have been sent to the Ombudsman office. During an interview on 12/22/2025 at 2:08 PM, the Administrator stated that Director of Social Services or social work team was responsible for sending the transfer discharge notices to the Ombudsman office. The Administrator stated that the discharge notice for Resident #118 should have been sent to the Ombudsman office as required. 10 NYCRR 415.3 |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interviews during a Recertification Survey initiated on 12/15/2025 and completed on 12/22/2025, the facility did not ensure that a comprehensive person-centered care plan was developed for each resident that included measurable objectives and timeframes to meet each resident's medical and nursing needs. This was identified for one (1) (Resident #79) of five (5) residents reviewed for Unnecessary Mediations. Specifically, Resident #79 had a physician's order for Methenamine Hippurate (a urinary tract antiseptic for a history of Urinary Tract Infection. There was no documented evidence that a comprehensive person-centered care plan was developed to address the long-term use of a urinary tract antiseptic drug. The finding is:The facility policy titled Comprehensive Care Plans dated 09/2025, documented a comprehensive assessment of the resident's needs will be prepared and developed by the interdisciplinary team. Informatician obtained from the comprehensive assessment and staff interviews enable the facility staff to plan care that focuses on each resident's ability to achieve their highest practicable mode of function that includes but not limited to past medical history, and drug therapy. The comprehensive care plan will be revised or a new care plan developed quarterly, annually and as needed.Resident #79 was admitted with diagnoses that included bacterial infection unspecified (bacteria in the body causing illness, but a specific germ or location is not identified), chronic obstructive pulmonary disorder (a progressive lung disease that blocks airflow, causing breathing difficulties), and Alzheimer's disease. The Quarterly Minimum Data Set assessment dated [DATE], documented Resident #79 had a Brief Interview for Mental Status score of 00, indicting the resident had severe cognitive impairment. The Quarterly Minimum Data Set assessment documented Resident #79 was frequently incontinent. A physician order dated 07/19/022 last reviewed on 11/27/2025, documented Methenamine Hippurate (a urinary tract antiseptic)1 gram tablet twice a day for a personal history of Urinary Tract Infection.A review of the current Comprehensive Care Plans had no documentation for the current use of prophylactic antibiotics for reoccurring Urinary Tract Infections.During an interview on 02/19/2025 at 8:02 AM, Registered Nurse Supervisor #2 stated Resident #79 is currently on a prophylactic medication for Urinary Tract Infections and has been since 2022. The care plan for reoccurring Urinary Tract Infections was resolved inadvertently and should not have been resolved. Registered Nurse Supervisor #2 stated that there should have been a current comprehensive care plan to address the resident's history of Urinary Tract Infections and use of a long-term urinary antiseptic. During an interview on 12/19/2025 at 3:36 PM the Director of Nursing Services stated a care plan should be in place for the use of a long-term prophylactic medication. The nursing supervisors and registered nurses were responsible to initiate and update the care plans. The Licensed Practical Nurses could also update the care plan. 10 NYCRR 415.11(c)(1) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews the facility did not ensure that services provided or arranged by the facility met the current professional standards of quality. This was identified for one (1) (Resident # 112) of eight (8) residents during the medication administration task. Specifically, Resident #112 had physician's orders to flush the feeding tube before medication administration and in between each medication administration. Licensed Practical Nurse #9 was observed administering medications without flushing the feeding tube before and after the medication administration. The finding is: The facility's Enteral (feeding) Tube Feeding policy dated 11/03/2025 documented it is the policy of the facility to provide enteral nutrition and hydration when by mouth intake is not an adequate option. [Physician] Orders shall include the amount of water to flush the feeding tube before and after feeding, or otherwise. Flushing the feeding tube on a routine basis (before and after medication administration, before and after feeding) will be designated by Registered Dietician and Medical Doctor. Resident #112 was admitted with diagnoses including cerebral infarction (sudden blockage of an artery supplying the brain), dysphagia (difficulty swallowing), and gastrostomy (tube feeding status). The Annual Minimum Data Set assessment dated [DATE] documented the resident could not complete the Brief Interview for Mental Status assessment because the resident was rarely or never understood. The resident was utilizing a feeding tube for nutrition. The physician's orders dated 12/06/2025 documented give 30 milliliters of water via Percutaneous Endoscopic Gastrostomy tube (feeding tube) prior to medication administration; 10 milliliters of water via feeding tube after each medication; and Jevity 1.5 formula via bolus feeding (a syringe and gravity is used to feed directly into the stomach through a feeding tube) 237 milliliters five (5) times a day at 6:00 AM, 10:00AM, 2:00 PM, 6:00 PM and 10:00 PM; and 60 milliliters of water before and after each feeding . The physician order dated on 11/14/2025 documented Tylenol (pain medication) 325 milligrams tablet give two (2) tablets (650 mg) every eight (8) hours as needed. Crush and administer the medication via the feeding tube. The care plan for Percutaneous Endoscopic Gastrostomy tube (feeding tube) dated 04/12/2025 documented the interventions including to administer feeding formula with required amount of water as prescribed by the feeding, check feeding tube patency and position before each feeding, check gastric residuals before each feeding and document the amount. The care plan for dehydration/Fluid Maintenance dated 10/07/2024 documented the resident was at risk for dehydration due to potential for electrolyte imbalance, pressure ulcers/wounds, dementia, altered mental status, dependence on staff for fluids, and dysphagia. Interventions included to monitor for signs and symptoms of dehydration; monitor labs as ordered by the Physician; and provide tube feeds and water flushes per physician orders. During an observation of Resident #112's medication administration on 12/17/2025 at 4:50 AM, Licensed Practical Nurse #9 completed Resident #112's bolus feeding but did not administer 60 milliliters of water before and after the feeding as per the physician orders. Licensed Practical Nurse #9 also administered two tablets of Tylenol 325 milligrams but did not administer 30 milliliters of water before the medication administration and 10 milliliters of water after the medication was administered. During an interview on 12/17/2025 at 6:00 AM, Licensed Practical Nurse #9 stated they forgot to give the resident 60 milliliters of water before and after the bolus feeding, 30 milliliters of water before the medication administration, and 10 milliliters of water afterwards because they were nervous. Licensed Practical Nurse #9 stated it was important to flush the feeding tube for patency to prevent any blockage and maintain the resident's hydration. During an interview on 12/17/2025 at 07:03 AM, Registered Nurse Supervisor #4 stated the nurses must follow the physician's orders, the facility policy and the resident's care to maintain the resident's tube feeding patency and hydration. During an interview on 12/19/2025 at 3:42 PM, the Director of Nursing Services stated that all nurses must follow the physician's orders to flush the feeding tube before and after bolus feedings and medication administration to maintain patency and hydration. 10 NYCRR 415.11(c)(3)(i) |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews the facility did not ensure a resident who is fed with enteral means receives the appropriate treatment and services to prevent potential complications of enteral feeding including but not limited to dehydration. This was identified for one (1) (Resident # 112) of eight (8) residents observed during the medication administration task. Specifically, Resident #112 had physician's orders to flush the feeding tube before medication administration and in between each medication administration. Licensed Practical Nurse #9 was observed administering medications without flushing the feeding tube before and after the medication administration. The finding is: The facility's Enteral Tube Feeding policy dated 11/03/2025 documented to provide enteral nutrition and hydration when by mouth intake is not an adequate option. [Physician] Orders shall include the amount of water to flush the feeding tube before and after feeding, or otherwise. Flushing the feeding tube on a routine basis (before and after medication administration, before and after feeding) will be designated by the Registered Dietician and the Physician. Resident #112 was admitted with diagnoses including cerebral infarction (sudden blockage of an artery supplying the brain), dysphagia (difficulty swallowing), and gastrostomy (tube feeding status). The Annual Minimum Data Set assessment dated [DATE] documented the resident could not complete the Brief Interview for Mental Status assessment because the resident was rarely or never understood. The resident was utilizing a feeding tube for nutrition. The physician's orders dated 12/06/2025 documented give 30 milliliters of water via Percutaneous Endoscopic Gastrostomy tube (feeding tube) prior to medication administration; 10 milliliters of water via feeding tube after each medication; and Jevity 1.5 formula via bolus feeding (a syringe and gravity is used to feed directly into the stomach through a feeding tube) 237 milliliters five (5) times a day at 6:00 AM, 10:00AM, 2:00 PM, 6:00 PM and 10:00 PM; and 60 milliliters of water before and after each feeding . The physician order dated on 11/14/2025 documented Tylenol (pain medication) 325 milligrams tablet give two (2) tablets (650 mg) every eight (8) hours as needed. Crush and administer the medication via the feeding tube. The care plan for Percutaneous Endoscopic Gastrostomy tube (feeding tube) dated 04/12/2025 documented interventions including to administer feeding formula with required amount of water as prescribed by the Physician; check feeding tube patency and position before each feeding; and check gastric residuals before each feeding and document the amount. The care plan for dehydration/Fluid Maintenance dated 10/07/2024 documented the resident was at risk for dehydration due to potential for electrolyte imbalance, pressure ulcers/wounds, dementia, altered mental status, dependence on staff for fluids, and dysphagia. Interventions included to monitor for signs and symptoms of dehydration; monitor labs as ordered by the Physician; and provide tube feeds and water flushes per physician orders. During an observation of Resident #112's medication administration on 12/17/2025 at 4:50 AM, Licensed Practical Nurse #9 completed Resident #112's bolus feeding but did not administer 60 milliliters of water before and after the feeding as per the physician orders. Licensed Practical Nurse #9 also administered two tablets of Tylenol 325 milligrams but did not administer 30 milliliters of water before the medication administration and 10 milliliters of water after the medication was administered. During an interview on 12/17/2025 at 6:00 AM, Licensed Practical Nurse #9 stated they forgot to give the resident 60 milliliters of water before and after the bolus feeding, 30 milliliters of water before the medication administration, and 10 milliliters of water afterwards because they were nervous. Licensed Practical Nurse #9 stated it was important to flush the feeding tube for patency to prevent any blockage and maintain the resident's hydration. During an interview on 12/17/2025 at 07:03 AM, Registered Nurse Supervisor #4 stated the nurses must follow the physician's orders, the facility policy, and the resident's care plan to maintain the resident's tube feeding patency and hydration. During an interview on 12/19/2025 at 8:39 AM, Physician #1 stated it<br>(continued on next page) |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | was important for nurses to maintain tube feeding patency and hydration and follow the physician's orders regarding flushing the feeding tube with water before and after the bolus feeding and medication administration. During an interview on 12/19/2025 at 3:42 PM, the Director of Nursing Services stated that all nurses must follow the physician's orders to flush the feeding tube before and after bolus feedings and medication administration to maintain patency and hydration. 10 NYCRR 415.12(g)(2) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews the facility did not ensure that residents requiring respiratory care were provided such care in accordance with professional standards of practice. This was identified for one (1) (Resident #9) of three (3) residents reviewed for Respiratory Care. Specifically, Resident #9 has a diagnosis of Chronic Obstructive Pulmonary Disease (lung disease characterized by persistent air flow limitation and chronic inflammation in the airways and lungs) and a physician's order for two (2) liters of supplemental oxygen to be administered as needed via a nasal cannula. On three (3) different observations, Resident #9 was observed receiving supplemental oxygen via nasal cannula at three (3) liters per minute.The finding is: The facility's Oxygen Therapy Administration policy dated 05/14/2025 documented that oxygen therapy must be ordered by a Physician. The procedure included to post the Oxygen in use sign and set the [oxygen] flow rate at the prescribed liter per minute. Resident #9 was admitted with diagnoses including chronic obstructive disease, atrial fibrillation, and dependence on supplemental oxygen. The quarterly Minimum Data Set assessment dated [DATE] documented the resident had a Brief Interview of Mental Status score of 14, which indicated the resident was cognitively intact. The assessment documented the resident received oxygen therapy and had no behaviors including rejection of care. The resident had an impairment to their upper and lower extremities and had functional limitations in range of motion. The physician's orders renewed on 11/29/2025 documented to check Oxygen Saturation every shift and as needed; administer oxygen therapy as needed at a flow rate of two (2) liters per minute for comfort and when the resident's pulse oxygen saturation is less than 90%. The care plan entitled Respiratory Disorder for Chronic Obstructive Pulmonary Disease initiated on 09/10/2019 documented the resident was at risk for respiratory distress due to the diagnosis of Chronic Obstructive Pulmonary Disease. The interventions included to assess the resident's level of anxiety, elevate head of bed to above 45 degrees due to shortness of breath while lying flat, and administer oxygen therapy as per the physician's order. During separate observations on 12/15/2025 at 10:32 AM, 12/16/2025 at 2:13 PM, and 12/17/2025 at 10:50 AM, Resident #9 was lying in their bed receiving oxygen therapy via nasal cannula. The oxygen flow rate was set to three (3) liters per minute on each observation. The Medication Administration Record for December 2025 documented the resident's oxygen saturation levels each shift. The oxygen saturation levels were measured to be above 90% (normal range 92% and above) except on 12/15/2025 during the 3:00 PM-11:00 PM shift where the levels were recorded to be 74%. During an interview on 12/17/2025 at 10:51 AM, Resident #9 stated they preferred to always have oxygen therapy because it makes them feel better due to their diagnosis of Chronic Obstructive Pulmonary Disease. Resident #9 stated they always need the oxygen on for their lungs. During an interview on 12/17/2025 at 8:05 AM, Certified Nursing Assistant #3 stated they were the regular dayshift aide for Resident #9 and the nurses were responsible of Oxygen administration. Certified Nursing Assistant #3 stated they did not see the resident adjusting the oxygen. Certified Nursing Assistant #3 stated the resident prefers to continuously receive the oxygen therapy. During an interview on 12/17/2025 at 10:53 AM, Licensed Practical Nurse #4 stated Resident #9 prefers to continuously receive supplemental oxygen. Licensed Practical Nurse #4 stated they did not know the oxygen flow rate was set to three (3) liters per minute. Licensed Practical Nurse#4 stated it was important to follow the physician's orders which currently prescribed oxygen therapy at two (2) liters per minute via nasal cannula. During an interview on 12/17/2025 at 11:04 AM, Registered Nurse Supervisor #3 stated that it was important for the resident to receive oxygen therapy as prescribed by the Physician because the resident has a diagnosis of chronic obstructive pulmonary disease. Registered Nurse Supervisor #3 stated increasing the oxygen flow rate can harm the resident. During an interview on 12/19/2025 at 8:52 AM, Physician #1 stated the nurses have to follow the physician's orders for oxygen therapy and if the nurses increase the oxygen flow rate, they (continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 335390 | A. Building<br>B. Wing | 12/22/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Surge Rehabilitation and Nursing LLC | 49 Oakcrest Ave<br>Middle Island, NY 11953 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | have to let the Physician know and obtain a physician's order. Physician #1 stated they would need to examine the resident and determine if an increase of oxygen therapy is needed. During an interview on 12/19/2025 at 3:42 PM, the Director of Nursing Services stated the nurses should follow the physician's order for the oxygen therapy for safety and effectiveness of the treatment. The Director of Nursing Services stated if there is a need for increase in the oxygen flow rate, the nurses should have notified the Physician to evaluate the resident. 10 NYCRR 415.12(k)(6) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to maintain an infection prevention and control program to help prevent the transmission of communicable diseases and infections. This was identified for one (1) (Resident #112) of eight (8) residents during the medication administration task. Specifically, Resident #112 had a Percutaneous Endoscopic Gastrostomy tube (feeding tube) and a physician's order for enhanced barrier precautions. Licensed Practical Nurse #9 did not perform hand hygiene prior to going to Resident #112's room; did not utilize personal protective equipment while administering Resident #112's medications; and handled the resident's feeding tube without the use of gloves.The finding is: The facility's Enhanced Barrier Precautions Policy dated 04/28/2025 documented to adhere to the Center for Disease Control's enhanced barrier precautions (EBPs) guidelines to prevent the transmission of multidrug-resistant organism (MDROs) while promoting resident quality of life. Enhanced barrier precautions require the use of personal protective equipment including a gown and gloves. The hand washing policy dated 04/28/2025 documented the facility encourages frequent hand hygiene, both handwashing and the use of alcohol-based hand sanitizers, consistent with accepted standards of practice. Frequent hand hygiene with an alcohol-based hand sanitizer throughout the day is recommended under the following circumstances but not limited to: before beginning work and when leaving work, before and after touching a resident or the residents immediate environment. Resident #112 was admitted with diagnoses including cerebral infarction (sudden blockage of an artery supplying the brain), dysphagia (difficulty swallowing), and gastrostomy (tube feeding status). The Annual Minimum Data Set assessment dated [DATE] documented the resident could not complete the Brief Interview for Mental Status assessment because the resident was rarely or never understood. The resident was utilizing a feeding tube for nutrition. The Enhanced Barrier Precaution (EBP) Care plan dated 04/14/2025 documented the resident was at risk for infections due to an indwelling medical device as evidenced by a Percutaneous Endoscopic Gastrostomy (feeding) tube. Interventions included to maintain enhanced barrier precautions, monitor for signs and symptoms of infection, and use a gown and gloves during the high contact resident care activities. The care plan for Percutaneous Endoscopic Gastrostomy tube (feeding tube) dated 04/12/2025 documented interventions including to administer feeding formula with required amount of water as prescribed by the feeding; check feeding tube patency and position before each feeding; and check gastric residuals before each feeding and document the amount. The physician's orders dated 12/06/2025 documented give 30 milliliters of water via Percutaneous Endoscopic Gastrostomy tube (feeding tube) prior to medication administration; 10 milliliters of water via feeding tube after each medication; and Jevity 1.5 formula via bolus feeding (a syringe and gravity is used to feed directly into the stomach through a feeding tube) 237 milliliters five (5) times a day at 6:00 AM, 10:00AM, 2:00 PM, 6:00 PM and 10:00 PM; and 60 milliliters of water before and after each feeding . During an observation of Resident #112's medication administration on 12/17/2025 at 4:50 AM, an enhanced barrier precautions signage was posted on the room door, and personal protective equipment was available outside the room door. Licensed Practical Nurse #9 did not perform hand hygiene prior to going to Resident #112's room; did not utilize personal protective equipment while administering Resident #112's medications; and handled the resident's feeding tube without the use of gloves. During an interview on 12/17/2025 at 6:30 AM, Licensed Practical Nurse #9 stated they forgot to disinfect and wash their hands before starting the resident's medication administration. Licensed Practical Nurse #9 stated they should have used gloves when they handled the resident's feeding tube and did not because they forgot. Licensed Practical Nurse #9 stated they were supposed to follow the enhanced barrier precautions instructions including to wear a gown and use gloves while providing the direct care to prevent the spread of infections. During an interview on 12/17/2025 at 07:03 AM, Registered Nurse Supervisor #4 stated Licensed Practical Nurse #9 should<br>(continued on next page) |

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| | 335390 | A. Building<br>B. Wing | 12/22/2025 |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | have washed their hands before and after they provided care to Resident #112. Registered Nurse Supervisor #4 stated Licensed Practical Nurse #9 should have followed the infection control policy and utilized the personal protective equipment to prevent the spread of infections. During an interview on 12/17/2025 at 08:16 AM, the Infection Control Preventionist (Registered Nurse #1) stated all staff must follow the enhanced barrier precautions and use personal protective equipment while providing care. The Infection Control Preventionist stated staff members should perform hand hygiene before and after resident care and utilize gloves to handle the feeding tube to prevent infections. During an interview on 12/19/2025 at 3:42 PM, the Director of Nursing Services stated the nurses should follow the physician's order for enhanced barrier precautions and the infection control policy to prevent the spread of the infections. 10 NYCRR 415.19(a)(1-3)(b)(4) |